Colorado Indigent Care Program Client Authorization

For the Use and Disclosure of Protected Health Information

The Health Insurance Portability and Accountability Act of 1996 states that we cannot share your protected health information without your permission, except in certain situations. For example, your protected health information can be shared without your permission if it is used to facilitate your health care treatment, payment, to determine enrollment or eligibility for benefits, or for health plan operations. If you sign this form, you are giving us permission to share the protected health information you indicate below. This does not protect the information from being shared with more people once it leaves our office.

This authorization will only last until the date you specify, and must expire on a specific date or upon the occurrence of a specific event.

If you decide later that you do not want us to share your protected health information any more, you may cancel your authorization at any time by signing the REVOCATION SECTION at the end of this form and returning it to Colorado Department of Health Care Policy and Financing Privacy Officer indicated above. Any revocation can only apply to future disclosures or actions regarding your protected health information and cannot cancel actions taken or disclosures made while the authorization was in effect. See the Department's Privacy Policies and Procedures on *Use and Disclosure of Protected Health Information – Authorization Required*, pursuant to 45 C.F.R. 164.508.

Date:	
I, group to disclose Care Policy and	(print your name) authorize the following person or emy protected health information with the Colorado Department of Health Financing:
The following inf	ormation may be disclosed:
Information	related to eligibility for benefits for the following time period (specify dates):
From:	To:
	n including claims, reports, and other documents related to claims for benefits from a e period (specify dates):
From	То
Information specific da	n relating to payment or lack of payment of benefits for services rendered on a te:
Date:	Name of health care provider:

☐ Other (specify):

Expiration of authorization: (You must specify a date or event, i.e., at the end of litigation) Date / event of expiration: Covered entities under HIPAA may not condition treatment, payment, enrollment or eligibility for health plan benefits on receipt of an authorization.
Name: Signature:
Date of birth: Social Security #:
Name of Designated Personal Representative: *** Legal documentation must be included to show authority to receive information ***
Signature of Designated Personal Representative:
Relationship of Designated Personal Representative:
REVOCATION SECTION
I understand that I have the right to revoke this authorization at any time. I understand that the revocation is only effective after it is received. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.
I no longer want my protected health information used or disclosed.
Signature: Date:

This form must be received by the Colorado Indigent Care Program administration prior to any discussion with a third party (i.e. hospital, clinic or billing agent) a client's eligibility for benefits; information including claims, reports, and other documents related to claims for benefits; or information relating to payment or lack of payment of benefits for services rendered. Without this form, the Colorado Indigent Care Program will not discuss any client specific issues with any provider or outside agent.

Fax 303-866-4411

Attention: Colorado Indigent Care Program

1570 Grant Street Denver, CO 80439-1818